GEORGIA DEPARTMENT OF COMMUNITY HEALTH

ANTIDIABETIC AGENTS PA SUMMARY

Preferred Medications	Non-Preferred Medications
Preferred DPP-4 Inhibitors Onglyza (saxagliptin) - requires PA Kombiglyze (saxagliptin/metformin) - requires PA ***Preferred Meglitinides*** Prandimet (repaglinide/metformin) Prandin (repaglinide) Starlix (nateglinide) ***Preferred Metformin Products*** Metformin generic Metformin ER generic Riomet (metformin) ***Preferred Sulfonylureas*** Glimepiride generic Glipizide generic Glyburide generic ***Preferred Thiazolidinediones (TZD)*** Pioglitazone generic ***Preferred Miscellaneous Antidiabetic Agents*** Byetta (exenatide) - requires PA SymlinPen (pramlintide) – requires PA Victoza (liraglutide) – requires PA ***Preferred Alpha-Glucosidase Inhibitors*** Acarbose generic Miglitol generic	***Non-Preferred DPP-4 Inhibitors*** Januvia (sitagliptin) Janumet (sitagliptin/metformin) Janumet XR (sitagliptin/metformin) extended-release Jentadueto (linagliptin/metformin) Juvisync (sitagliptin/simvastatin) Kazano (alogliptin/metformin) Nesina (alogliptin) Oseni (alogliptin/pioglitazone) Tradjenta (linagliptin) ***Non-Preferred Meglitinides*** Nateglinide generic Repaglinide generic ***Non-Preferred Metformin Products*** Fortamet ER (metformin SR 24hr) Glumetza ER (metformin SR 24hr) Metformin SR 24 hr (generic Fortamet ER) ***Non-Preferred Sodium-Glucose Co-Transporter 2 Inhibitors*** Farxiga (dapagliflozin) Invokamet (canagliflozin/metformin) Invokana (canagliflozin) Jardiance (empagliflozin) ***Non-Preferred Sulfonylureas*** Chlorpropamide generic Tolazamide generic Tolbutamide generic ***Non-Preferred Thiazolidinediones (TZD)*** Actoplus Met XR (pioglitazone/metformin ER) Duetact (pioglitazone/glimepiride) Pioglitazone/glimepiride generic Pioglitazone/metformin generic ***Non-Preferred Miscellaneous Antidiabetic Agents*** Bydureon (exenatide ER) Cycloset (bromocriptine) Tanzeum (albiglutide) Trulicity (dulaglutide)

LENGTH OF AUTHORIZATION: Varies

NOTES:

- Insulins and Diabetic Supplies/Insulin Pens have separate PA criteria.
- Preferred and non-preferred DPP-4 Inhibitors and Miscellaneous Agents require prior authorization.

Revised 2/9/2015

- If pioglitazone/glimepiride (generic) is approved, the PA will be issued for brand-name Duetact.

PA CRITERIA:

For Onglyza, Kombiglyze

- Approvable for members with Type 2 diabetes mellitus

AND

- Member must have experienced an inadequate response, allergies, contraindications, drug-drug interactions, or intolerable side effects to metformin and either a thiazolidinedione or a sulfonylurea

AND

- Submit documentation of hemoglobin A1c results within the past 3 months.
- Kombiglyze may be approved if the member has been taking Onglyza as a single-ingredient product. Otherwise, requests for Kombiglyze must meet the criteria above.

For Januvia, Janumet, Janumet XR, Kazano, Nesina, Tradjenta

- Approvable for members with Type 2 diabetes mellitus

AND

- Member must have experienced an inadequate response, allergies, contraindications, drug-drug interactions, or show a history of intolerable side effects to Onglyza

AND

- Submit documentation of hemoglobin A1c results within the past 3 months.

For Jentadueto

- Submit a written letter of medical necessity stating the reason(s) the separate products, metformin and Tradjenta, are not appropriate for the member.

For Juvisync

- Submit a written letter of medical necessity stating the reason(s) the separate products, simvastatin and Januvia, are not appropriate for the member.

For Oseni

- Submit a written letter of medical necessity stating the reason(s) the separate products, Actos and Nesina, are not appropriate for the member.

For Nateglinide

- Prescriber should submit a written letter of medical necessity stating the reasons that brand-name Starlix is not appropriate for the member.

For Repaglinide

- Prescriber should submit a written letter of medical necessity stating the reasons that brand-name Prandin is not appropriate for the member.

For Fortamet ER (brand), Glumetza ER, or Metformin SR 24hr (generic Fortamet ER)

- Physician should submit a written letter of medical necessity stating the reason(s) the preferred product, metformin ER, is not appropriate for the member.

For Farxiga, Invokana and Jardiance

- Approvable for members 18 years of age or older with Type 2 diabetes mellitus
- Prescribers should submit documentation of hemoglobin A1c results within the past 3 months.
- Members must have had an inadequate response, allergy, contraindication, drug-drug interaction, or a history of intolerable side effects to metformin and either a thiazolidinedione or sulfonylurea.

For Invokamet

- Submit a written letter of medical necessity stating the reason(s) the separate products, metformin and Invokana, are not appropriate for the member.

For Chlorpropamide, Tolazamide and Tolbutamide

- Member must have experienced ineffectiveness, allergies, contraindications, drug-drug interactions, or a history of intolerable side effects to at least 2 preferred sulfonylurea products.

For Actoplus Met XR

- Physician should submit a written letter of medical necessity stating the reasons that pioglitazone and metformin ER (generic Glucophage XR), as two separate prescriptions, are not appropriate for the member.

For Duetact or Pioglitazone/Glimepiride

- Physician should submit a written letter of medical necessity stating the reasons that pioglitazone and glimepiride, as two separate prescriptions, are not appropriate for the member.

For Pioglitazone/Metformin

- Physician should submit a written letter of medical necessity stating the reasons that pioglitazone and metformin, as two separate prescriptions, are not appropriate for the member.

For Byetta

- Approvable for members with type 2 diabetes currently on metformin, sulfonylurea, or thiazolidinedione therapy or combination therapy with metformin + sulfonylurea or metformin + thiazolidinedione.
- Submit documentation of hemoglobin A1c results within the past 3 months.

For Bydureon

- Approvable for members with type 2 diabetes currently on metformin, sulfonylurea, or thiazolidinedione therapy or combination therapy with metformin + sulfonylurea or metformin + thiazolidinedione.
- Submit documentation of hemoglobin A1c results within the past 3 months.
- For members who have not tried Byetta for at least three months, Bydureon requires a written letter of medical necessity stating the reasons(s) that Byetta is not appropriate for the member (and must meet Byetta criteria above).

- Alternatively, Bydureon may be approvable if member has tried Byetta for at least three months and experienced ineffectiveness or intolerable side effects that are not expected with Bydureon.

For SymlinPen

- Approvable for members ages 18 and older with diabetes who are receiving insulin.
- Provider must submit documentation of HgbA1c level completed within the past 3 months.

For Tanzeum and Trulicity

- Approvable for members with type 2 diabetes currently on metformin, sulfonylurea, or thiazolidinedione therapy or combination therapy with metformin + sulfonylurea or metformin + thiazolidinedione who have tried and failed therapy with Byetta and Victoza.
- Submit documentation of hemoglobin A1c results within the past 3 months.

For Victoza

- Approvable for members with type 2 diabetes currently on metformin, sulfonylurea, or thiazolidinedione therapy or combination therapy with metformin + sulfonylurea or metformin + thiazolidinedione
- Submit documentation of hemoglobin A1c results within the past 3 months.

For Cycloset

- Approvable for members with type 2 diabetes who have had an inadequate response, allergy, contraindication, drug-drug interaction, or a history of intolerable side effects to metformin, sulfonylurea, thiazolidinedione and dipeptidyl-peptidase-IV inhibitor.
- Submit documentation of hemoglobin A1c results within the past 3 months.

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **Catamaran at 1-866-525-5827.**

PA and APPEAL PROCESS:

- For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.